



# Improving the Value of Medical Care

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## Background

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Conventional Issues

○ Access

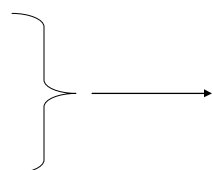
○ Cost

○ Quality

Real Issues

○ Access

○ Value



Spending money isn't bad. Wasting money is.

## An Assessment of Value

		Should Be Done	
		<u>Yes</u>	<u>No</u>
Is Done	Yes	+	Acute
	No	Chronic	+

## Where is there money to be saved?

- Insurance premiums: administrative cost
  - Average is 15%; could cut by 2/3
  - Solution: group small firms into large pools.
- Care receipt: overused care
  - About 25-30 percent of care is not needed
- Care provision: Lots of inefficiency within institutions
- *As much as 50% of medical care might be wasteful – up to \$1 trillion of benefit if we get it right*



## Insurance Administration

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- Nearly \$100 billion is spent on private insurance administration (14% of PHI)
  - Federal gov't spends \$26 bn (4% of Federal health spending)
- Big issue: eliminating individual/small group risk rating.
  - Community rating
  - Purchasing pools



## Examples of Overused Care

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- Medical care in the US vs. ...
- Medical care in Massachusetts vs. ...
- Wennberg et al.: Bringing Medicare spending to the level of the 25<sup>th</sup> percentile would save 25-30%.



## Examples of Underused Care

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- Chronic disease control is no better than 1 in 3.
- People find system confusing to use.
- Use of IT is extremely low.



## Options

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<u>Global caps</u>	<u>Demand-side</u>	<u>Supply-side</u>
Fixed amt of \$\$\$; Technology caps; Tight fee limits	Increased cost sharing	Pay-for- performance; Health IT
It's what other countries do	Consumers will drive efficiency improvement	Provider incentives are key

All rely on a strong information base: price and quality information provided to consumers



## What Do We Know? Demand Side

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- Use is sensitive to patient cost sharing
  - Moving to catastrophic coverage might save 25% (???), \$300 billion.
- Problems:
  - Will patients give up care that is valuable?
    - The statin example
  - Will this lead to adverse selection?



## What Do We Know? Supply-Side

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- Each has potential
  - Rand: HIT could save \$77 bn / year
  - Prices influence what is done
  - Actual evidence is limited (hard to test it on a small scale)
- Problems:
  - Up front costs (\$150 bn for HIT)
  - Potential adverse incentives (gaming the system)
  - Uncooperative MDs (get MDs to design)



## Collective Action is Key

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- Set ambitious quality/cost goals
  - Eliminate errors, reduce paperwork, lower cost relative to trend, etc.
- Measure cost and quality outcomes
- Commit to supply-side reforms
  - Performance-based payment
  - Health IT financing (loans, grants, conditioned payments)



## Example – Eastern Massachusetts Healthcare Initiative

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- Goals
  - Eliminate hospital-acquired infection
  - Analyze variation in care
  - Develop a plan for interoperable IT
- Timeframe
  - Make significant progress in 1<sup>st</sup> year
- Funding
  - From institutions



## The Challenge

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*Some area has to be the leader in  
the 21<sup>st</sup> century health care system.  
Which area will it be?*